King County

VETERANS AND HUMAN SERVICES LEVY
2008 STRATEGY AREA ANNUAL REPORTS

Activity 2.4(a)
Investment in support services for housing – Housing Health Outreach Team

OBJECTIVE

The Levy's investment in Strategy 2 focuses on ending long-term homelessness through a variety of interventions including identification, outreach, prevention, housing, supportive services and education. Strategy 2.4(a) is designed to support formerly homeless individuals and families in permanent housing through a Housing Health Outreach Team in permanent supportive housing sites.

POPULATION FOCUS

This program prioritizes single adults in Seattle and South King County who were previously homeless. The client population characteristically has mental health and substance abuse conditions, including Post Traumatic Stress Disorder. Many of those served are veterans.

PROGRAM DESCRIPTION

The Housing Health Outreach Team (HHOT) is comprised of two distinct teams that operate separately in South King County and Seattle.

- In Seattle, an interdisciplinary team provides services in ten selected permanent supportive housing sites for formerly homeless adults. Medical services are provided by 3.4 Full-time Equivalent (FTE) nurse positions and 0.2 FTE physician employed by Neighborcare Health (formerly Puget Sound Neighborhood Health Centers). A 1.0 FTE mental health practitioner is also contracted through Neighborcare Health. Two FTE chemical dependency providers on the team are employed by Evergreen Treatment Services. The team coordinates closely with housing support staff to connect formerly homeless residents with primary care, mental health, and chemical dependency services in the community.

- In South King County, a cross-agency team includes a 1.0 FTE nurse employed by HealthPoint (formerly Community Health Centers of King County) who works closely with staff of Sound Mental Health (SMH) to connect residents of SMH's South County Housing First Pilot project to primary care. Residents are similarly formerly homeless and are challenged by mental health and addiction history.

The Health Care for the Homeless Network within Public Health-Seattle & King County manages the contracts for HHOT services and coordinates a steering committee that meets quarterly. The HHOT team's sites include projects that place vulnerable homeless individuals into housing with on-site support services, as well as other selected permanent supportive housing sites with high levels of unmet health care needs, such as sites experiencing high levels of 911 calls.

PROGRESS DURING 2008

The HHOT team is comprised of providers from three different community health providers.

Agency	Veterans Funds Awarded	Human Services Funds	Total Levy Funds Awarded
Evergreen Treatment Services	$3,960	$9,240	$13,200
HealthPoint	$19,982	$46,625	$66,607
Neighborcare Health	$24,768	$57,792	$82,560
Total	**$48,710**	**$113,657**	**$162,367**

Neighborcare Health was awarded the HHOT downtown Seattle medical services contract during a competitive RFP process in 2007. HealthPoint was sole-sourced for South King County because it was considered to be the only community clinic in South King County that could feasibly take on this body of work at that time. Evergreen Treatment Services was sole-sourced to provide chemical dependency services, as an extension of the REACH team which provides chemical dependency case management services to currently homeless adults in downtown Seattle.

Services began in Seattle in May 2007 and in South King County in June 2008.

SERVICES PROVIDED

Number Served. A total of 598 people have been served by the HHOT: 581 in Seattle and 17 in South King County.

Total Served	East	North	Seattle	South
598			581	17

Living Situation. Because the HHOT program serves people who have been placed in a permanent supportive housing unit, none of those served by the program were currently homeless at that time they received HHOT services. However, all had been homeless or at risk of homelessness in the past.

Living Situation	
Homeless	0
Not Homeless	598

Age Group. Most of those served who provided information ranged from 35 to 59 years old.

Age Group	
0 to 5	
6 to 10	
11 to 13	
14 to17	
18 to 34	34
35 to 59	434
60 to 74	117
75 to 84	12
85 and over	1

Gender. Women served by this project significantly outnumbered men.

Gender	
Male	155
Female	440
Transgender	2
Unknown	1

Race. People of all races have been served by HHOT, but just over half of those served are white.

Race		
American Indian or Alaska Native	54	9.0%
Asian, Asian-American	13	2.2%
Black, African-American, Other African	136	22.7%
Hawaiian Native or Pacific Islander	4	0.7%
Hispanic, Latino	33	5.5%
Multi-Racial	17	2.8%
Other Non-White/Non-Caucasian	13	2.2%
White or Caucasian	316	52.8%
Unknown (must be > or = 0)	12	2.0%

Veteran Status. Approximately 21% of those served by the program were veterans or active service members.

Veterans/Military Status		
Veterans or Active Service persons	124	20.7%
Spouses of veterans or active military persons		
Military or Veterans' Children or Dependents		
Non Military or Veteran eligible clients	457	76.4%
Unknown (must be > or = 0)	17	2.8%

Outcomes. The HHOT provided health care linkages and support to 598 clients who are formerly homeless and living in King County. The team of medical, mental health, and chemical dependency providers helped clients establish a regular health care regimen, rather than relying on costly emergency care. In 2008, 180 clients were linked to primary health care services. In total, 152 residents with mental health or chemical dependency conditions engaged in services for those conditions.

As contractors within the Health Care for the Homeless Network, providers monitor when they set self management goals[1] with clients. Self-management support refers to a way of working with people to help them improve their health. Patients are actively involved in identifying small and achievable steps they will take. The health provider then works with them to discuss challenges and successes along the way. For example, a patient may decide to read a pamphlet to learn more about their condition, or a diabetic patient may decide to exchange one food for another for the week. In 2008, 212 residents with chronic health conditions set a self management goal.

In addition to helping clients with health goals, the HHOT project aimed to increase or maintain the housing stability of individuals, families and households, as measured by the number of clients remaining in stable housing for at least one year.

[1] Institute for Health Care Improvement's Chronic Care Model. For more information: www.improvingchroniccare.org or http://www.healthdisparities.net/hdc/html/home.aspx.

Of the 598 clients of the Housing Health Outreach Team, 436 were measured for this outcome. Those not measured included 132 clients who were housed less than 12 months only because they moved into the buildings during 2008. In addition, 16 died during the year. The team was unable to attain tenancy information from the housing providers on 14 of the clients. Of the 436 clients measured, only 2% (10 clients) moved out after less than one year and have unknown housing status. Those who moved out may have moved into other housing, skilled nursing facilities, or returned to homelessness.

In 2008, the downtown Seattle HHOT team participated in several activities to improve care, such as a team retreat in the fall, communicable disease training provided by the Health Care for the Homeless Network, and advanced wound care training. The team began conducting formal case presentations twice monthly. The nurses provided flu shots to approximately 300 people across all of their sites. The medical providers on the team moved to a new location at the Pike Market Medical Clinic, which helped improve communication and collaboration with clinic providers.

SUCCESS STORY

Tom* was homeless for many years before moving into a supportive housing building in downtown Seattle. He spent much of his life in prison, and struggles with a heroin addiction. Tom suffers from chronic pneumonia, chronic obstructive pulmonary disorder, and congestive heart failure, which resulted in numerous emergency room visits and monthly hospitalizations. In 2008, the housing support staff where he lives connected the Housing Health Outreach Team (HHOT) on Tom's behalf. Several members of the team developed a relationship with Tom over the next few months. The HHOT chemical dependency provider sited in his building helped him access methadone treatment for his addiction, and he subsequently ended his heroin use. The HHOT medical provider who visits his building helps Tom manage his medications for his chronic medical conditions, and helps him remain connected to routine medical care. Thanks to assistance from the HHOT team, Tom greatly reduced his hospital admissions and emergency room visits in the past six months. In February 2009, Tom was diagnosed with liver cancer. Even with this life-threatening news, Tom continues to work on his healthcare goals.

* Name changed

FOR MORE INFORMATION

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